

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0018580</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER				
Facility Name: <u>Selfhelp Home of Chicago</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/99</u> to <u>9/30/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.				
Address: <u>908 W. Argyle Road</u> <u>Chicago</u> <u>60640</u> <div style="display: flex; justify-content: space-between; width: 100%;"> Number City Zip Code </div>		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.				
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____				
Telephone Number: <u>(773) 271-0300</u> Fax # <u>(773) 271-0633</u>		Paid Preparer (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin & Glasser LLP</u> <u>1 South Wacker Drive</u> <u>Chicago, IL 60606-7494</u> (Telephone) <u>(312) 636-3400</u> Fax # <u>(312) 634-5518</u>				
IDPA ID Number: <u>362521053001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # <u>(217) 782-1630</u>				
Date of Initial License for Current Owners: <u>01/01/57</u>						
Type of Ownership: <table border="0" style="width: 100%;"> <tr> <td style="width: 33%; vertical-align: top;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(c)(3)</u> </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table>		<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u>501(c)(3)</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		
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In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-4580</u> <u>Altschuler, Melvoin & Glasser LLP</u> <u>1 South Wacker Drive</u> <u>Chicago, IL 60606-7494</u>						

Please send copies of any desk review or audit adjustments to the above address.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago# 0018580 Report Period Beginning: 10/01/99 Ending: 9/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>30</u>	Skilled (SNF)	<u>30</u>	<u>10,980</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>35</u>	Intermediate (ICF)	<u>35</u>	<u>12,810</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>65</u>	TOTALS	<u>65</u>	<u>23,790</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>234</u>	<u>6,059</u>		<u>6,293</u>	8
9	SNF/PED					9
10	ICF	<u>3,462</u>	<u>11,108</u>		<u>14,570</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,696</u>	<u>17,167</u>		<u>20,863</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 87.70%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/57

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date N/ANO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒

If YES, enter number

of beds certified N/A and days of care provided Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐Tax Year: 9/30/00 Fiscal Year: 9/30/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning: 10/01/99

Ending: 9/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7 **	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	259,990		7,403	267,393		267,393		267,393		1
2	Food Purchase		176,183		176,183		176,183	(2,519)	173,664		2
3	Housekeeping	87,393	18,300		105,693		105,693		105,693		3
4	Laundry		27,400		27,400		27,400		27,400		4
5	Heat and Other Utilities			52,293	52,293		52,293		52,293		5
6	Maintenance	48,204		38,014	86,218		86,218	45,165	131,383		6
7	Other (specify):*										7
8	TOTAL General Services	395,587	221,883	97,710	715,180		715,180	42,646	757,826		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,102,468	81,903	7,155	1,191,526		1,191,526		1,191,526		10
10a	Therapy										10a
11	Activities	79,652	7,513	1,173	88,338		88,338		88,338		11
12	Social Services			2,096	2,096		2,096		2,096		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,182,120	89,416	10,424	1,281,960		1,281,960		1,281,960		16
	C. General Administration										
17	Administrative	95,063			95,063		95,063		95,063		17
18	Directors Fees										18
19	Professional Services			30,003	30,003		30,003		30,003		19
20	Dues, Fees, Subscriptions & Promotions			6,482	6,482		6,482		6,482		20
21	Clerical & General Office Expenses	95,049	5,501	26,545	127,095		127,095	(7,491)	119,604		21
22	Employee Benefits & Payroll Taxes			334,957	334,957		334,957		334,957		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,165	4,165		4,165		4,165		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	TOTAL General Administration	190,112	5,501	402,152	597,765		597,765	(7,491)	590,274		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,767,819	316,800	510,286	2,594,905		2,594,905	35,155	2,630,060		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Selfhelp Home of Chicago

#0018580

Report Period Beginning:

10/01/99

Ending:

9/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7 **	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			58,614	58,614		58,614	43,402	102,016			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			54,180	54,180		54,180	(54,180)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			112,794	112,794		112,794	(10,778)	102,016			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		220		220		220		220			41
42	Provider Participation Fee			35,686	35,686		35,686		35,686			42
43	Other (specify):* Nonallowable costs	9,120		28,630	37,750		37,750	(37,750)				43
44	TOTAL Special Cost Centers	9,120	220	64,316	73,656		73,656	(37,750)	35,906			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,776,939	317,020	687,396	2,781,355		2,781,355	(13,373)	2,767,982			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning: 10/01/99

Ending: 9/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,519)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(45,899)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(13,331)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule 5A	(31,910)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (93,659)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	80,286		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 80,286		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (13,373)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Selfhelp of Chicago, Inc. d/b/a The Selfhelp Home, Inc.

PROVIDER # 0018580

September 30, 2000

Schedule 5A

VI. ADJUSTMENT DETAIL

NON-ALLOWABLE EXPENSES

LINE 29 - Other

Description	Amount	Schedule V
		Reference
Disallow Outreach Program	(396)	43
Disallow Gift Shop Purchases	(10,311)	43
Disallow Public Relations	(2,863)	43
Disallow Support Collateral	(266)	43
Disallow Marketing Salaries	(9,120)	43
Disallow Internet Expense	(1,463)	43
Income Offset	(7,491)	21
Total	(31,910)	

See Accountants' Compilation Report

NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1	\$	1
2		2
3		3
4		4
5		5
6		6
7		7
8		8
9		9
10		10
11		11
12		12
13		13
14		14
15		15
16		16
17		17
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72		72
73		73
74		74
75		75
76		76
77		77
78		78
79		79
80		80
81		81
82		82
83		83
84		84
85		85
86		86
87		87
88		88
89		89
90 Total	0	90

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning: 10/01/99 Ending: 9/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				The Selfhelp		
				Home, Inc. -	Chicago	Lessor
				Center Division		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	6	Maintenance	\$	The Selfhelp Home, Inc. - Center Division	0.00%	\$ 45,165	\$ 45,165	1
2	V	30	Depreciation		The Selfhelp Home, Inc. - Center Division	0.00%	89,301	89,301	2
3	V	34	Rent	54,180	The Selfhelp Home, Inc. - Center Division	0.00%		(54,180)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 54,180			\$ 134,466	\$ * 80,286	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago # 0018580 Report Period Beginning: 10/01/99 Ending: 9/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	See Attached Schedule 7A										3
4											4
5											5
6			No compensation or fees paid to the Board of Directors								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

Selfhelp of Chicago, Inc. d/b/a The Selfhelp Home, Inc.
PROVIDER # 0018580
September 30, 2000

Schedule 7A

Name	Title	Function
Herbert Roth	President	Board Member
Rolf Weil	Imm. Past President	Board Member
Gerald Franks	First Vice-President	Board Member
Bernard Baum	Vice President	Board Member
Austin Hirsch	Vice President	Board Member
Leni Weil	Treasurer	Board Member
Steven Loewenthal	Assistant Treasurer	Board Member
Henry Straus	Secretary	Board Member
Louise Franks	Chairman, Friends of Selfhelp	Board Member
Linda Liss Fine	Director of Resident Services	Board Member
Marvin Rubin	Director of Administrative Services	Board Member
Cathy Wolfson	Director of Community Relations	Board Member
Jack Bierig	Director	Board Member
Richard Eggener	Director	Board Member
Hanna Goldschmidt	Director	Board Member
Richard Greenthal	Director	Board Member
M. Jay Heilbrunn	Director	Board Member
Suzanne Kach	Director	Board Member
Kurt B. Karmin	Director	Board Member
Martha Loewenthal	Director	Board Member
Margot Meyer	Director	Board Member
Stephen Nechtow	Director	Board Member
Henry Nord	Director	Board Member
Klaus Ollendorff	Director	Board Member
Barbara Passman	Director	Board Member
Michael Ries	Director	Board Member
George Rosenbaum	Director	Board Member
Steven Strauss	Director	Board Member
Marianne Weinberg	Director	Board Member
Daniel Wolf	Director	Board Member

See Accountants' Compilation Report

Facility Name & ID Number Selfhelp Home of Chicago# 0018580 Report Period Beginning: 10/01/99 Ending: 9/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13				N/A					13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8								N/A				8	
9	TOTAL Facility Related							\$	\$			\$	9
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related							\$	\$			\$	14
15	TOTALS (line 9+line14)							\$	\$			\$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Selfhelp Home of Chicago**# **0018580** Report Period Beginning: **10/01/99** Ending: **9/30/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	2
3. Under or (over) accrual (line 2 minus line 1).	\$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$ N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	8
	1996	9
	1997	10
	1998	11
	1999	N/A

	FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

A. Square Feet:

73,944

B. General Construction Type:

Exterior

Masonry

Frame

Steel

Number of Stories

3

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Selfhelp Home, Inc. : retirement facility 94 apartments

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized:

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	70,000	1970	\$ 191,769	1
2					2
3	TOTALS	70,000		\$ 191,769	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning:

10/01/99

Ending:

9/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	65		1974	1974	\$ 822,760	\$	50	\$ 16,455	\$ 16,455	\$ 419,608	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Security System			9/30/1980	786		15			786	9
10	Security System			9/30/1981	29,527		15			29,527	10
11	Building Improvements			9/30/1981	808		20	40	40	783	11
12	Building Improvements			9/30/1982	2,642		15			2,642	12
13	Building Improvements			9/30/1983	2,717		10			2,717	13
14	Building Improvements			9/30/1986	1,212		10			1,212	14
15	Building Improvements			9/30/1987	3,000		10			3,000	15
16	Building Improvements			9/30/1988	6,752		10			6,752	16
17	Building Improvements			9/30/1989	30,538		10			30,538	17
18	Building Improvements			9/30/1990	+ 10,425		10	517	517	10,425	18
19	Building Improvements			9/30/1991	9,690		10	969	969	9,206	19
20	Building Improvements			9/30/1992	22,014		10	2,201	2,201	18,709	20
21	Building Improvements			9/30/1992	+ 932		7			932	21
22	Building Improvements			9/30/1993	14,166		10	1,417	1,417	10,292	22
23	Building Improvements			9/30/1993	183		7	27	27	183	23
24	Building Improvements			9/30/1994	+ 27,620		10	2,762	2,762	17,953	24
25	Building Improvements			9/30/1994	+ 3,836		5	384	384	4,220	25
26	Building Improvements			9/30/1994	+ 5,148		7	735	735	4,778	26
27	Building Improvements			9/30/1995	18,411		10	1,841	1,841	10,126	27
28	Building Improvements			9/30/1995	363		7	52	52	286	28
29	Building Improvements			9/30/1995	+ 176,882	8,844	20	8,844		48,642	29
30	Building Improvements			9/30/1995	+ 15,209		5	1,520	1,520	15,209	30
31	Building Improvements			9/30/1994	+ 33,000		5			33,000	31
32	Fence			9/30/1996	6,704	202	20	336	134	1,344	32
33	Decorating			9/30/1996	5,905	136	20	294	158	1,176	33
34	Blacktop Resurfacing			9/30/1996	1,646	50	20	82	32	328	34
35	Security Camera			9/30/1996	895	26	20	44	18	176	35
36	TOTAL (lines 4 thru 35)				\$ 1,253,771	\$ 9,258		\$ 38,520	\$ 29,262	\$ 684,550	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

+Cost adjusted to agree with capital report finalized 12/6/96

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning:

10/01/99

Ending:

9/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Boiler repairs			9/30/1996	5,914	158	20	296	138	1,184	9
10	Emergency call system			9/30/1996	14,557	58	20	728	670	2,912	10
11	Cabinets & vanities			9/30/1997	2,938	34	20	147	113	570	11
12	Fire Alarms			9/30/1997	12,818	486	20	641	155	2,321	12
13	Elevator Improvements			9/30/1997	6,171	98	20	309	211	1,187	13
14	Ceiling			9/30/1997	563		20	28	28	112	14
15	Tubing and piping			9/30/1997	1,667	19	20	83	64	323	15
16	Faucets			9/30/1997	999		20	50	50	200	16
17	Flooring			9/30/1997	2,152	80	20	108	28	392	17
18	Air Conditioning			9/30/1997	1,505		20	75	75	300	18
19	Doors			9/30/1997	7,523	214	20	376	162	1,397	19
20	Cement Work			9/30/1997	1,275	32	20	64	32	240	20
21	Windows			9/30/1997	51,709		20	2,585	2,585	10,340	21
22	Outdoor Sprinklers			9/30/1997	2,573	64	20	129	65	483	22
23	Bathtub & Toilet			9/30/1997	605		20	30	30	120	23
24	Tuckpointing			9/30/1997	4,583		20	229	229	916	24
25	Blinds			9/30/1997	1,255	63	20	63		220	25
26	Boiler			9/30/1997	1,097		20	55	55	220	26
27	Office Refurbishing			9/30/1997	908	33	20	45	12	164	27
28	Compressor and Base Board			9/30/1997	680		20	34	34	136	28
29	Fire Alarms			9/30/1998	20,992	524	20	1,050	526	2,887	29
30	Sound System			9/30/1998	862		20	43	43	129	30
31	Architect			9/30/1998	43,360	2,112	20	2,168	56	5,447	31
32	Windows			9/30/1998	4,588		20	229	229	687	32
33	Lights			9/30/1998	1,517		20	76	76	228	33
34	Kitchen Sink			9/30/1998	1,230	62	20	62		155	34
35											35
36	TOTAL (lines 4 thru 35)				\$ 194,041	\$ 4,037		\$ 9,703	\$ 5,666	\$ 33,270	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning:

10/01/99

Ending:

9/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Doors & Locks			9/30/1998	685		20	34	34	102	9
10	Audio/Visual System			9/30/1998	10,578	264	20	529	265	1,455	10
11	Wall/Windows			9/30/1998	2,222	62	20	111	49	302	11
12	Cabinets & Vanities			9/30/1998	1,300		20	65	65	195	12
13	Electrical Work			9/30/1998	11,441	284	20	572	288	1,574	13
14	Heating & Cooling			9/30/1998	9,470	236	20	474	238	1,303	14
15	Roof			9/30/1998	8,333		20	417	417	1,251	15
16	Floor Coverings			9/30/1998	3,067		20	153	153	459	16
17	Computer Wiring			9/30/1998	6,242	312	20	312		780	17
18	Handrails & Grab Bars			9/30/1998	6,020	301	20	301		753	18
19	Lights			9/30/1999	1,217		20	60	60	90	19
20	Floor Coverings			9/30/1999	4,564		20	228	228	342	20
21	Heating & Cooling			9/30/1999	1,373		20	68	68	102	21
22	Elevator			9/30/1999	37,272	194	20	1,864	1,670	2,796	22
23	Cabinets			9/30/1999	2,251		20	112	112	168	23
24	Wall			9/30/1999	2,790		20	140	140	210	24
25	Fire Alarm			9/30/1999	14,911	658	20	746	88	1,119	25
26	Roof			9/30/1999	35,283	160	20	1,597	1,437	2,479	26
27	Call/Paging System			9/30/1999	5,142	164	20	258	94	387	27
28	Pipes & Faucet			9/30/1999	865		20	44	44	66	28
29	Room Conversion			9/30/1999	3,169		20	158	158	237	29
30	Fire Ducts			9/30/1999	35,113	1,756	20	1,756		2,634	30
31	Security System			9/30/1999	13,503	676	20	676		1,014	31
32	Electrical Wiring			9/30/1999	20,805	1,040	20	1,040		1,560	32
33	Architect			9/30/1999	540	28	20	28		42	33
34	Blinds			2000	1,050		20	53	53	53	34
35											35
36	TOTAL (lines 4 thru 35)				\$ 239,206	\$ 6,135		\$ 11,796	\$ 5,661	\$ 21,473	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Cabinets		2000		3,135	23	20	134	111	134	9
10	Lobby Renovation		2000		3,397		20	170	170	170	10
11	Dining Room Renovation		2000		7,818	38	20	353	315	353	11
12	Washroom Renovation		2000		1,039		20	52	52	52	12
13	Light Fixtures		1999		893		20	45	45	45	13
14	Room Conversion		2000		673		20	34	34	34	14
15	Closet/Coat Room		2000		205		20	10	10	10	15
16	Doors		2000		1,568	5	20	73	68	73	16
17	Tiles		1999		140		20	7	7	7	17
18	Air Conditioner		2000		90		20	4	4	4	18
19	Resident Call System		2000		14,103	394	20	394		394	19
20	Heating & Cooling		2000		838		20	42	42	42	20
21	Ceiling Fan		1999		287		20	14	14	14	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 34,186	\$ 460		\$ 1,332	\$ 872	\$ 1,332	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 424,098	\$ 38,245	\$ 40,186	\$ 1,941	5-10	\$ 236,229	37
38	Current Year Purchases	4,793	479	479		5-10	479	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 428,891	\$ 38,724	\$ 40,665	\$ 1,941		\$ 236,708	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$			\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$			\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 2,341,864	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 58,614	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 102,016	49 **
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 43,402	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 977,333	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ N/A Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____

13. /2002 \$ _____

14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p><i>It is the policy of this facility to only hire certified nurses aides.</i></p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language										
2	Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs		N/A						7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 509,511	\$ 509,511	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 0)	39,264	39,264	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,000	6,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule 17A	68,173	68,173	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 622,948	\$ 622,948	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		191,769	13
14	Buildings, at Historical Cost		822,760	14
15	Leasehold Improvements, at Historical Cost	639,283	898,444	15
16	Equipment, at Historical Cost	224,952	428,891	16
17	Accumulated Depreciation (book methods)	(313,879)	(977,333)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 550,356	\$ 1,364,531	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,173,304	\$ 1,987,479	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 26,985	\$ 26,985	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,714	34,714	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,656	2,656	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	46,939	46,939	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 111,294	\$ 111,294	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule 17A	82,528	82,528	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 82,528	\$ 82,528	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 193,822	\$ 193,822	46
47	TOTAL EQUITY(page 18, line 24)	\$ 979,482	\$ 1,793,657	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,173,304	\$ 1,987,479	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Selfhelp of Chicago, Inc. d/b/a The Selfhelp Home, Inc.

PROVIDER # 0018580

September 30, 2000

Schedule 17A

XV. BALANCE SHEET -

Other Current Assets (specify):	After	
	Operating	Consolidation
Bequest Receivable	65,747	65,747
Scholarship Loan Receivable	8,600	8,600
Scholarship Loan Payable	(6,174)	(6,174)
Total Line 9 - Other Current Assets (specify):	68,173	68,173

Other Current Liabilities (specify):	After	
	Operating	Consolidation
Current Maturity Retirement Plan	6,000	6,000
Accrued Medical Expenses	4,550	4,550
Accrued Entertainment Expenses	(1,260)	(1,260)
Deferred Retirement Plan	37,649	37,649
Total Line 36 - Other Current Liabilities (specify):	46,939	46,939

Other Long-Term Liabilities (specify):	After	
	Operating	Consolidation
Interco A/C-Ries Fund	42	42
Interco A/C-Bonem Fund	26,848	26,848
Interco A/C-Scholarship	8,996	8,996
Interco A/C-Marx Fund	46,642	46,642
Total Line 43 - Other Long-Term Liabilities (specify):	82,528	82,528

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,208,838	1
2	Restatements (describe):		2
3	Cumulative activity of funds other than healthcare facility	(1,103,012)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,105,826	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(126,344)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (126,344)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 979,482	24 *

* This must agree with page 17, line 47.
Operating Entity Only

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Selfhelp Home of Chicago

0018580

Report Period Beginning: 10/01/99

Ending: 9/30/00

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,383,946	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,383,946	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	23,881	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,519	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 26,400	23
	D. Non-Operating Revenue		
24	Contributions	193,827	24
25	Interest and Other Investment Income***	41,872	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 235,699	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	8,966	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,966	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,655,011	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	715,180	31
32	Health Care	1,281,960	32
33	General Administration	597,765	33
	B. Capital Expense		
34	Ownership	112,794	34
	C. Ancillary Expense		
35	Special Cost Centers	37,970	35
36	Provider Participation Fee	35,686	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,781,355	40
41	Income before Income Taxes (line 30 minus line 40)**	(126,344)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (126,344)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.
Exempt Organizations

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Selfhelp Home of Chicago# 0018580Report Period Beginning: 10/01/99Ending: 9/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

(This schedule must cover the entire reporting period)						
		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,104	2,224	\$ 51,386	\$ 23.11	1
2	Assistant Director of Nursing	1,600	1,720	28,837	16.77	2
3	Registered Nurses	18,903	21,561	389,981	18.09	3
4	Licensed Practical Nurses	4,747	5,411	86,403	15.97	4
5	Nurse Aides & Orderlies	59,137	69,176	545,861	7.89	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,600	1,805	25,810	14.30	9
10	Activity Assistants	5,567	6,003	53,842	8.97	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,040	2,299	32,761	14.25	13
14	Head Cook	9,780	11,832	99,795	8.43	14
15	Cook Helpers/Assistants	20,748	23,637	127,434	5.39	15
16	Dishwashers					16
17	Maintenance Workers	3,731	3,908	48,204	12.33	17
18	Housekeepers	11,794	13,467	87,393	6.49	18
19	Laundry					19
20	Administrator	1,333	1,333	56,051	42.05	20
21	Assistant Administrator	1,600	1,600	39,012	24.38	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,875	6,806	95,049	13.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing</u>	393	393	9,120	23.21	33
34	TOTAL (lines 1 - 33)	150,952	173,175	\$ 1,776,939 *	\$ 10.26	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

B. CONSULTANT SERVICES		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	179	\$ 7,403	L1,C3	35
36	Medical Director				36
37	Medical Records Consultant	77	1,760	L10,C3	37
38	Nurse Consultant	25	1,963	L10,C3	38
39	Pharmacist Consultant	Monthly	2,650	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,173	L11,C3	44
45	Social Service Consultant	42	2,096	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	347	\$ 17,045		49

C. CONTRACT NURSES

C. CONTRACT NURSES		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	16	\$ 782	L10,C3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	16	\$ 782		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

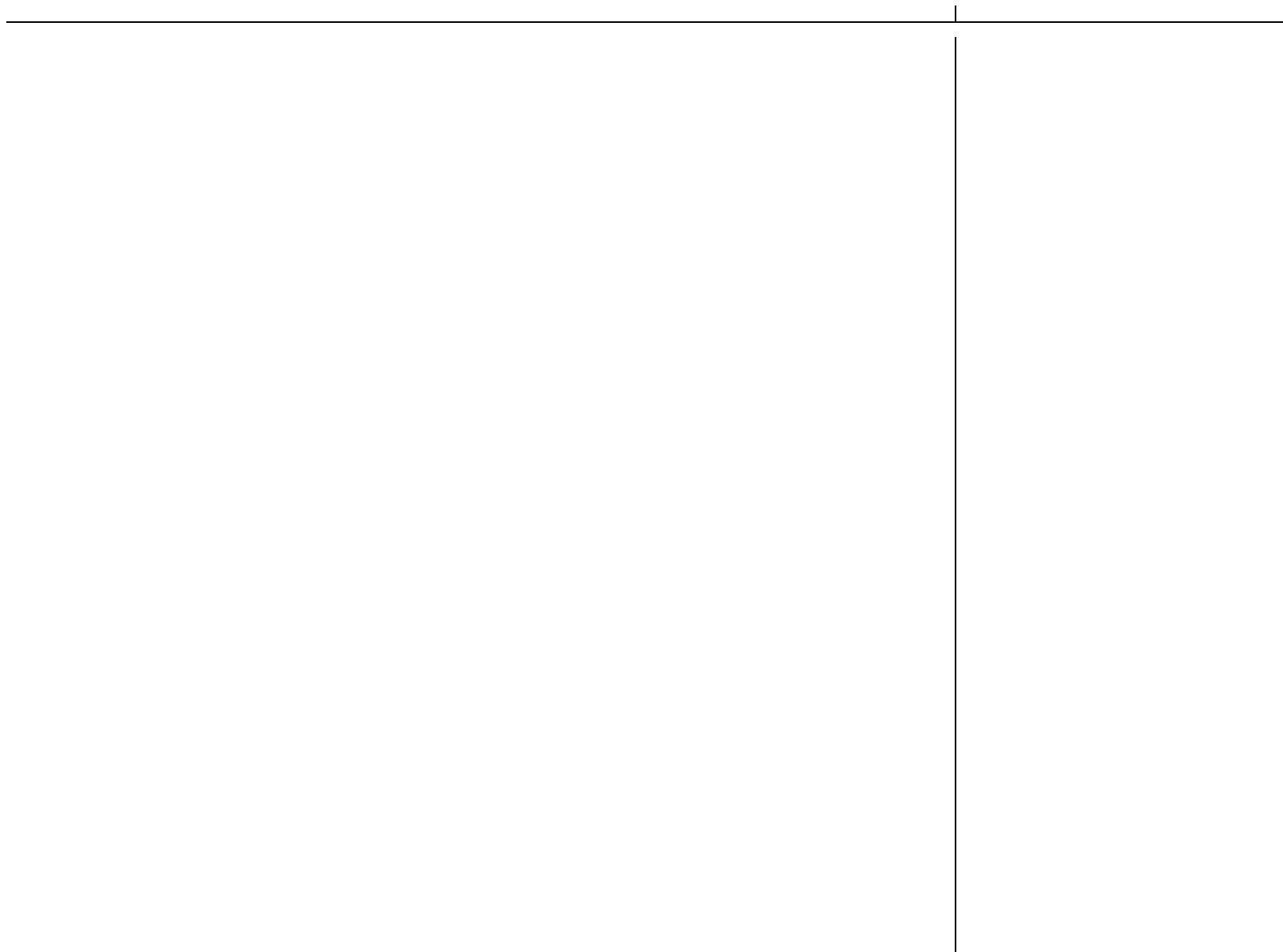
XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2		3		4		5		6		7		8		9		10		11		12		13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year																				
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005												
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
2																									
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20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

<p>Facility Name & ID Number Selfhelp Home of Chicago</p> <p>XX. GENERAL INFORMATION:</p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u> If YES, give association name and amount. <u>LSN \$ 4,454; IL Council \$1,482</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>6 Years</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>40,188</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation. _____</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? _____ YES <u>x</u> NO _____</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>x</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>N/A</u></p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ <u>35,686</u> This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>No</u> If YES, attach an explanation of the allocation. _____</p>	<p style="text-align: center;">STATE OF ILLINOIS</p> <p># 0018580 Report Period Beginning: 10/01/99 Ending: 9/30/00 Page 23</p> <hr/> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? <u>N/A</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>No</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>N/A</u> Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount. \$ <u>2,519</u></p> <p>(16) Travel and Transportation</p> <p style="margin-left: 20px;">a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation.</p> <p style="margin-left: 20px;">b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>N/A</u></p> <p style="margin-left: 20px;">c. What percent of all travel expense relates to transportation of nurses and patients? <u>0%</u></p> <p style="margin-left: 20px;">d. Have vehicle usage logs been maintained? <u>N/A</u></p> <p style="margin-left: 20px;">e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>N/A</u></p> <p style="margin-left: 20px;">f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u></p> <p style="margin-left: 20px;">g. Does the facility transport residents to and from day training? <u>N/A</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____</p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>Yes</u> Firm Name: <u>Altschuler, Melvoin & Glasser LLP</u> The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? <u>Yes</u> If no, please explain. _____</p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>N/A</u> Attach invoices and a summary of services for all architect and appraisal fees.</p>
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SEE ACCOUNTANTS' COMPILATION REPORT



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